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*Promoting and protecting the health of the public and the environment*

## **Frequently Asked Questions (FAQs)**

### **R. 61-122, Standards for Licensing In-Home Care Providers**

#### **1. What do I need to do to be licensed?**

Applicants for licensure as an in-home care provider shall submit the following documents to the Department:

- A complete and accurate application. The application must be signed by the owners if the applicant is an individual or a partnership; in the case of a corporation, by two of its officers.
- Evidence of liability insurance or, in lieu of liability insurance coverage, a surety bond. The minimum amount of coverage is one hundred thousand dollars (\$100,000) per occurrence and three hundred thousand dollars (\$300,000) aggregate.
- Evidence of indemnity coverage to compensate clients for injuries and losses resulting from services provided.
- Evidence of workers' compensation insurance in accordance with S.C. Code Ann. §§ 42-5-10, *et seq.*
- Evidence of criminal record checks and drug test results for the prospective licensee (i.e., those individuals signing the application for licensure).
- Evidence of a random drug testing program pursuant to S.C. Code Ann. § 44-70-70.
- A licensing fee. The initial license fee is in the amount of one thousand dollars (\$1,000). The renewal license fee is in the amount of eight hundred dollars (\$800).

#### **2. How do I get to the website for information?**

The DHEC webpage regarding in-home care providers is located at the following address:

<http://www.dhec.sc.gov/Health/FHPF/HealthFacilityRegulationsLicensing/HealthcareFacilityLicensing/FacilitySpecificInfo/In-HomeCareProviders/>

#### **3. What is an acceptable form of TB Testing? Who is permitted to perform the TB Testing? Who can perform the health assessment?**

All staff members and caregivers who have contact with clients shall have a health assessment within twelve (12) months prior to initial client contact. The health assessment shall include tuberculosis screening in a manner prescribed in the Center for Disease Control and Prevention's and the Department's most current tuberculosis guidelines.

A health assessment is an evaluation of the health status of a staff member or caregiver by a physician, other authorized healthcare provider, or registered nurse, pursuant to written standing orders and/or protocol approved by a physician's signature. The standing orders/protocol shall be reviewed annually by the physician, with a copy maintained at the facility.

Immediately following the FAQs, there is a copy of the *Tuberculosis Screening Guidelines Recommended by CDC and Established by DHEC* (“the Guidelines”). Section IV of the Guidelines explains the tuberculosis testing requirements for staff members and caregivers who will have client contact. According to the Guidelines, all healthcare workers, including staff members and caregivers for in-home care providers, are required to have a baseline two-step Tuberculin Skin Test (“TST”) or a single Blood Assay for Mycobacterium Tuberculosis (“BAMT”) within 3 months prior to contact with patients unless there is a documented TST or a BAMT result during the previous 12 months. If a newly employed healthcare worker had a documented negative TST or BAMT result within the previous 12 months, a single TST (or the single BAMT) can be administered in the new setting to serve as the baseline there.

Additionally, all in-home care providers shall conduct an annual tuberculosis risk assessment in the Appendix of Regulation 61-122 to determine the appropriateness and frequency of tuberculosis screening and other tuberculosis related measures to be taken.

**4. We are an existing in-home care provider. When does Regulation 61-122 become effective? How long will the process take to be licensed? When can I submit my application for licensure?**

Regulation 61-122 became effective on June 27, 2014. The Department will begin accepting applications for licensure on August 1, 2014. Please submit your application for licensure to the Department on August 1, 2014. Applications will be processed as soon as possible in the order that they are received.

**5. How do I get a background check? Who is subject to the random drug testing? If I am an owner outside the State of South Carolina, am I subject to the random drug testing?**

**LICENSEES –**

Upon initial licensure, prospective licensees (i.e., the individuals signing the application) are required to provide evidence of state and national fingerprint-based criminal background checks and provide evidence of drug test results. Additionally, new signatories on renewal applications will be required to provide evidence of state and national fingerprint-based criminal records checks. Persons signing renewal applications who previously underwent state and national fingerprint-based criminal records checks upon initial licensure will not be required to undergo subsequent criminal records checks.

**CAREGIVERS –**

Prior to being employed by an in-home care provider, caregivers shall undergo a criminal background check and submit to a drug test. Please refer to the following webpage for guidance on the procedures for conducting criminal records checks for direct caregivers: <http://www.dhec.sc.gov/health/docs/DCGProcedures.pdf>. Caregivers shall not have prior convictions or have pled no contest (nolo contendere) to crimes related to theft, abuse, neglect, or exploitation of a child or vulnerable adult, for child or adult abuse, neglect or mistreatment, or a criminal offense similar in nature to the crimes listed in this subsection. Further, caregivers shall not have prior convictions or have pled no contest (nolo contendere) to crimes related to drugs within ten years of providing in-home care to clients.

**RANDOM DRUG TESTING –**

Licensees of in-home care providers, regardless of their locations, and individuals employed by in-home care providers as caregivers are subject to and must pass random drug testing. At a minimum, a five panel drug screen will be utilized that tests for cannabis, cocaine, amphetamines, opiates, and phencyclidine.

**6. Can I have an office in my home?**

Yes, in-home care providers may utilize an office in their residence. However, please ensure that you are in compliance with all other applicable local laws (i.e., zoning and business permits). Also, regardless of the location of the in-home care provider’s office, the provider shall ensure that it is accessible in person, by phone,

or page during the hours of 9:00 a.m. to 5:00 p.m., Monday through Friday, except for those holidays recognized by the State of South Carolina. The staff members who are required to be available as described above shall have access to all records required for routine inspections and complaint investigations.

**7. If I am an independent caretaker, am I required to obtain a license?**

An in-home care provider does not include an individual hired directly by the person receiving care or hired by his family. Thus, such individuals are not required to obtain licensure from the Department.

June 23, 2006

**ADDENDUM**

**Tuberculosis Screening Guidelines Recommended by CDC  
and Established by DHEC**

**SECTION I. References**

CDC Guidelines for Preventing Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. *MMWR* Vol. 54, No. RR-17, December 30, 2005.  
<http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf>

**SECTION II. Definitions**

A. Airborne Infection Isolation (AII): A room designed to maintain Airborne Infection Isolation, formerly called a negative pressure isolation room. An Airborne Infection Isolation room is a single-occupancy client-care room used to isolate persons with suspected or confirmed infectious tuberculosis (TB) disease. Environmental factors are controlled in Airborne Infection Isolation rooms to minimize the transmission of infectious agents that are usually spread from person-to-person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. Airborne Infection Isolation rooms shall provide negative pressure in the room (so that air flows under the door gap into the room), an air flow rate of 6–12 air changes per hour (ACH), and direct exhaust of air from the room to the outside of the building or recirculation of air through a high efficiency particulate air (HEPA) filter.

B. Blood Assay for *Mycobacterium tuberculosis* (BAMT): A general term to refer to recently-developed in vitro diagnostic tests that assess for the presence of infection with *M. tuberculosis*. This term includes, but is not limited to, IFN- $\gamma$  release assays (IGRA). In the United States, the currently available test is QuantiFERON®-TB Gold test (QFT-G).

C. Contact Investigation: Procedures that occur when a case of infectious TB is identified, including finding persons (contacts) exposed to the case, testing and evaluation of contacts to identify Latent TB Infection (LTBI) or TB disease, and treatment of these persons, as indicated.

D. Healthcare Worker (HCW): All paid persons (employees/staff) and unpaid persons (volunteers) working in the healthcare setting who have the potential for exposure to *M. tuberculosis* through air space shared with persons with infectious pulmonary TB disease.

E. Latent TB Infection (LTBI): Infection with *M. tuberculosis*. Persons with Latent TB Infection carry the organism that causes TB but do not have TB disease, are asymptomatic, and are noninfectious. Such persons usually have a positive reaction to the tuberculin skin test.

F. Tuberculin Skin Test (TST): A diagnostic aid for detecting *M. tuberculosis* infection. A small dose (0.1 ml) of purified protein derivative (PPD) tuberculin is injected just beneath the surface of the skin (by the Mantoux method), and the area is examined for induration (hard, dense, raised area at the site of Tuberculin Skin Test (TST) administration) by palpation 48–72 hours after the injection (but positive reactions can still be measurable up to a week after Tuberculin Skin Test (TST) administration). The size of the indurated area is measured with a millimeter ruler after identifying the margins transverse (perpendicular) to the long axis of the forearm. The reading is recorded in millimeters, including 0 mm to represent no induration. Redness/erythema is insignificant and is not measured or recorded.

G. Two-Step Testing: Procedure used for the baseline skin testing of persons who may periodically receive Tuberculin Skin Tests (TST) to reduce the likelihood of mistaking a boosted reaction for a new infection. If the initial Tuberculin Skin Test (TST) result is interpreted as negative, a second test is repeated 1-3 weeks after the initial test. If the initial Tuberculin Skin Test (TST) result is interpreted as positive, then the reaction shall be documented and followed up as positive; this reaction will serve as the baseline and no further skin testing is indicated. If the second test is given and its result is interpreted as positive, then the reaction shall be documented and followed up as positive; this reaction will serve as the baseline reading and no further skin testing is indicated. In general, the result of the second Tuberculin Skin Test (TST) of the two-step procedure shall be used as the baseline reading.

### **SECTION III. Risk Assessment For Settings In Which Clients With Suspected Or Confirmed TB Disease Are Not Expected To Be Encountered**

A. The initial and ongoing risk assessment for these settings shall consist of the following steps (use of applicable elements of the TB risk assessment worksheets found as Appendix B in the CDC Guidelines for Preventing Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. *MMWR* Vol. 54, No. RR-17, December 30, 2005 at <http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf> may be helpful):

1. Review the community profile of TB disease in collaboration with the local or state health department;
2. Consult the local or state TB control program to obtain epidemiologic surveillance data necessary to conduct a TB risk assessment for the healthcare setting (available on the DHEC website at <http://www.scdhec.gov/health/disease/tb>);
3. Determine if persons with unrecognized TB disease were encountered in the setting during the previous 5 years;
4. Determine if any healthcare workers (*i.e.*, employees, staff, volunteers) need to be included in the TB screening program;
5. Determine the types of environmental controls that are currently in place, and determine if any are needed in the setting;
6. Document procedures that ensure the prompt recognition and evaluation of suspected episodes of healthcare-associated transmission of *M. tuberculosis*;
7. Conduct periodic reassessments at least annually to ensure 1) proper implementation of the TB infection control plan; 2) prompt detection and evaluation of suspected TB cases; 3) prompt initiation of airborne precautions of suspected infectious TB cases before transfer; 4) prompt transfer of suspected infectious TB cases; 5) proper functioning of environmental controls, as applicable; and 6) ongoing TB training and education for healthcare workers (*i.e.*, employees, staff, volunteers);
8. Recognize and correct lapses in infection control.

B. The risk classification shall be used as part of the risk assessment to determine the need for an ongoing TB screening program for healthcare workers (*i.e.*, employees, staff, volunteers) and clients and the frequency of screening (CDC TB Guidelines, Appendix C). A risk classification shall be determined for the entire setting. However, in certain settings (*e.g.*, healthcare organizations that encompass multiple sites or types of services), specific areas defined by geography, functional units, patient population, job type, or location within the setting might have separate risk classifications.

## **SECTION IV. TB Testing Requirements For Settings In Which Clients With Suspected or Confirmed TB Disease Are Not Expected To Be Encountered**

### **A. Healthcare Workers (*i.e.*, employees, staff, volunteers)**

#### **1. Low Risk**

a. Baseline two-step Tuberculin Skin Test (TST) or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): All healthcare workers (*i.e.*, employees, staff, volunteers) (within 3 months prior to contact with clients) unless there is a documented Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result during the previous 12 months. If a newly employed healthcare worker (*i.e.*, employee, staff, volunteer) has had a documented negative Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result within the previous 12 months, a single Tuberculin Skin Test (TST) (or the single Blood Assay for *Mycobacterium tuberculosis* (BAMT)) can be administered in the new setting to serve as the baseline there.

b. Serial (periodic) Tuberculin Skin Test (TST) or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): Not indicated (not required).

c. Post-exposure Tuberculin Skin Tests (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) for healthcare workers (*i.e.*, employees, staff, volunteers) upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) as soon as possible to all healthcare workers (*i.e.*, employees, staff, volunteers) who have had unprotected exposure to an infectious TB case/suspect. If the Tuberculin Skin Test (TST) or the Blood Assay for *Mycobacterium tuberculosis* (BAMT) result is negative, administer another Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) 8-10 weeks after that exposure to *M. tuberculosis* ended.

#### **2. Medium Risk**

a. Baseline two-step Tuberculin Skin Test (TST) or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): All healthcare workers (*i.e.*, employees, staff, volunteers) (within 3 months prior to contact with clients) unless there is a documented Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result during the previous 12 months. If a newly employed healthcare worker (*i.e.*, employee, staff, volunteer) has had a documented negative Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result within the previous 12 months, a single Tuberculin Skin Test (TST) (or the single Blood Assay for *Mycobacterium tuberculosis* (BAMT)) can be administered in the new setting to serve as the baseline.

b. Serial (periodic) testing (with Tuberculin Skin Test (TST) or Blood Assay for *Mycobacterium tuberculosis* (BAMT)): Annually, of all healthcare workers (*i.e.*, employees, staff, volunteers) who have risk of TB exposure and who have previous documented negative results. Instead of participating in serial (periodic) testing, healthcare workers (*i.e.*, employees, staff, volunteers) with documented TB infection (positive Tuberculin Skin Test (TST) or Blood Assay for *Mycobacterium tuberculosis* (BAMT)) shall receive a symptom screen annually. This screen shall be accomplished by educating the healthcare worker (*i.e.*, employee, staff, volunteer) about symptoms of TB disease (including the healthcare workers (*i.e.*, employees, staff, volunteers) responses), documenting the questioning of the healthcare worker (*i.e.*, employee, staff, volunteer) about the presence of symptoms of TB disease, and instructing the healthcare worker (*i.e.*, employees, staff, volunteers) to report any such symptoms immediately to the administrator or director of nursing. Treatment for latent TB infection (LTBI) shall be considered in accordance with CDC/DHEC guidelines and, if recommended, treatment completion shall be encouraged.

c. Post-exposure Tuberculin Skin Tests (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) for healthcare workers (*i.e.*, employees, staff, volunteers) upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) as soon as possible to all healthcare workers (*i.e.*, employees, staff, volunteers) who have had unprotected exposure to an infectious TB case/suspect. If the Tuberculin Skin Test (TST) or the Blood Assay for *Mycobacterium tuberculosis* (BAMT) result is negative, administer another Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) 8-10 weeks after that exposure to *M. tuberculosis* ended.

### 3. Baseline Positive or Newly Positive Test Result

a. Healthcare workers (*i.e.*, employees, staff, volunteers) with a baseline positive or newly positive test result for *M. tuberculosis* infection (*i.e.*, Tuberculin Skin Test (TST) or Blood Assay for *Mycobacterium tuberculosis* (BAMT)) or documentation of treatment for latent TB infection (LTBI) or TB disease or signs or symptoms of tuberculosis (*e.g.*, cough, weight loss, night sweats, fever, *etc.*) shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy within the previous 3 months). These healthcare workers (*i.e.*, employees, staff, volunteers) will be evaluated for the need for treatment of TB disease or latent TB infection (LTBI) and will be encouraged to follow the recommendations made by a physician with TB expertise (*i.e.*, DHEC TB Control program).

b. Healthcare workers (*i.e.*, employees, staff, volunteers) who are known or suspected to have TB disease shall be excluded from work, required to undergo evaluation by a licensed physician, and permitted to return to work ONLY with approval by the DHEC TB Control program. Repeat chest radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a physician.

## B. Clients

### 1. For Low Risk and Medium Risk

a. Admission/Baseline two-step Tuberculin Skin Test (TST) or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): All clients within one month prior to admission unless there is a documented Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result during the previous 12 months. If a newly-admitted client has had a documented negative Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) result within the previous 12 months, a single Tuberculin Skin Test (TST) (or the single Blood Assay for *Mycobacterium tuberculosis* (BAMT)) can be administered within one month prior to admission to this facility to serve as the baseline.

b. Serial (periodic) Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT): Not indicated (not required).

c. Post-exposure Tuberculin Skin Tests (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) for clients upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) as soon as possible to all clients who have had exposure to an infectious TB case/suspect. If the Tuberculin Skin Test (TST) or the Blood Assay for *Mycobacterium tuberculosis* (BAMT) result is negative, administer another Tuberculin Skin Test (TST) or a Blood Assay for *Mycobacterium tuberculosis* (BAMT) 8-10 weeks after that exposure to *M. tuberculosis* ended.

### 2. Baseline Positive or Newly Positive Test Result

a. Clients with a baseline positive or newly positive test result for *M. tuberculosis* infection (*i.e.*, Tuberculin Skin Test (TST) or Blood Assay for *Mycobacterium tuberculosis* (BAMT)) or documentation of

treatment for latent TB infection (LTBI) or TB disease or signs or symptoms of tuberculosis (*e.g.*, cough, weight loss, night sweats, fever, *etc.*) shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy within the previous 3 months). Routine repeat chest radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a physician. These clients will be evaluated for the need for treatment of TB disease or latent TB infection (LTBI) and will be encouraged to follow the recommendations made by a physician with TB expertise (*i.e.*, DHEC TB Control program).

b. Residents who are known or suspected to have TB disease shall be transferred from the facility if the facility does not have an Airborne Infection Isolation room, required to undergo evaluation by a licensed physician, and permitted to return to the facility ONLY with approval by the DHEC TB Control program.